Terms of Reference

The effectiveness of the special arrangements established in 1999 under section 100 of the National Health Act 1953, for the supply of Pharmaceutical Benefits Scheme (PBS) medicines to remote area Aboriginal Health Services, with particular reference to:

(a) whether these arrangements adequately address barriers experienced by Aboriginal and Torres Strait Islander people living in remote areas of Australia in accessing essential medicines through the PBS;

Since inception of the current arrangements barriers in access to essential medicines have been greatly reduced for many Indigenous people in remote regions of the NT. However, three main barriers are seen to still exist:

1. Some communities, that would appear to be otherwise suitable to receive the benefits of S100 arrangements relative to existing beneficiaries, are still unable to access medicines through the S100 arrangements. While it is understood that not every community should be eligible for this system, there is significant ambiguity in the selection criteria, creating disparity in service provision capacity for similar health centres.

   The National Health Act 1953 contains provision to facilitate access to medicines for persons living in an isolated area, where adequate supply of pharmaceuticals is not available. While this was originally implemented as the selection criteria, it has since evolved to consider other factors when determining eligibility of a site for the S100 arrangements. The factors that are currently considered are:

   - Remoteness (according to RRMA category)
   - Distance to closest pharmacy service
   - Percentage of the population that identify themselves as Indigenous

   While each of these factors are valid considerations in this context, there is significant inconsistency in their application and differing levels of priority given to each factor, when eligibility is being assessed. This inconsistency sees some urban Aboriginal Medical Services (AMS) accessing S100 arrangements, while others are excluded. It also means that some remote health services are not able to access the arrangements, while others with similar population demographics and geographical isolation, can. Understandably clients of services, who are deemed not to meet the criteria, face significant disadvantage in accessing essential medicines.

   A review of the current selection criteria, with a view to maintaining a consistent approach would be beneficial in addressing this gap.

2. The second major deficit in the current system is that it does not acknowledge the mobility of the clients it aims to serve. Currently clients can only access S100 medicines while at their remote residential location. However if clients are temporarily in an urban setting, often to access medical services or as escort to someone who is, they are unable to access medicines

under S100. Programs such as the Closing the Gap initiative (CTG) and other AMS funded programs are not readily available to these clients. (CTG is the common use term for the form of additional subsidy of PBS medicines for Indigenous clients under the Indigenous Health Incentive, a raft of practice incentives as part of the Indigenous Chronic Disease package. CTG forms a component of this and allows eligible clients of Indigenous Health Services to obtain PBS medicines at a greater rate of subsidy.) The complexity of administration of these systems and the limited capacity of urban AMSs to manage these additional clients often means these services go unused. As a consequence clients often discontinue taking their medicines due to this access barrier, resulting in under management of the condition and clinical deterioration.

Similarly, due to the burden of illness faced by this population, hospital inpatient care in urban centres is often required. Upon discharge from hospital, clients are provided with a limited supply of medicines or are expected to pay a co-payment if a full Pharmaceutical Benefits Scheme quantity is supplied. In reality these clients are rarely able to meet the co-payment and therefore receive the limited supply only. However, these clients often face delays of varying lengths when returning to their remote residential location. This is often due to circumstances outside their control, such as limited transport options or ongoing specialist/outpatient treatment requirements. In these cases a substantial barrier to access then remains, as clients are unable to access S100 medicines during the interim period between when discharge medicines are completed and additional supplies can be accessed in their home community. As a result clients frequently face clinical deterioration and readmission to hospitals.

In summary the multiple funding arrangements in place need to be simplified to allow clients who are eligible under S100 to have on-going access to medications regardless of where they are receiving care. Understandably, limitations would need to be applied to avoid abuse of these arrangements.

3. Another barrier is capacity for clients to self manage their medicines. Since its inception, the current arrangements have done little to support the application of the principles of the Quality Use of Medicine (QUM) such as client education, drug usage review for appropriateness and safety. The lack of a direct pharmacist – patient relationship has resulted in little progress in developing client understanding of medicines, their role in health improvement, particularly in chronic disease management and the need to maintain adherence to medicine regimes. If this is then considered in the context of limited access to other clinical services due to distance and isolation, it is clear that this presents a significant barrier to achieving appropriate medicine usage.

While it is acknowledged that the current arrangements have made significant inroads into improving access to essential medicines for remote NT Indigenous people, the current arrangements have not effectively addressed all the problems clients face in accessing essential medicines. As such, a review of the arrangement with a view to creating a more comprehensive approach, taking into account these deficits, is recommended.

(b) the clinical outcomes achieved from the measure, in particular to improvements in patient

understanding of, and adherence to, prescribed treatment as a result of the improved access to PBS medicines;

As access to essential medicines is a fundamental component of the delivery of a comprehensive health service, it is reasonable that the implementation of this arrangement has had a positive impact on these outcomes. As several initiatives have been implemented during this period however, it would be difficult to quantify the magnitude of benefit on health outcomes directly attributable to this arrangement.

The current model has little allowance for pharmacist led clinical services and therefore the impact of patient understanding of and adherence to medicine regime has been minimal. The site visit allowance supports minimal time within remote health centres. These visits are typically utilised to establish and maintain storage and supply systems. Very little time is available during the supply process or during site visits, to assist patients in improving their understanding of medicines and the need for adherence to prescribed regimes. As clients' capacity to self manage medicines should be seen as an essential factor in managing chronic illness and improving health outcomes, this represents a significant deficiency of the current arrangement.

In less remote settings, QUM initiatives, such as the Home Medicines Review (HMR) model, often facilitate client understanding and adherence. In remote communities of the NT this has had minimal application for several reasons. The major barrier to its success has been because the funding structure is based on a home visit model for urban settings. In a bid to implement this model in a remote setting, fly-in fly-out visits are being undertaken, but there is little support to cover the additional costs of travel and accommodation to these locations. Additionally appointment mechanisms and coordination of clients can be challenging in the remote setting. As a result visiting HMR pharmacists often will only see a very small number of clients on each visit. As reimbursement is based on the number of reviews conducted, this model often proves non viable.

One potential solution is to directly support health services in implementing dedicated QUM services and programs. This will build on the access benefit currently being seen, allow safer and more effective use of the medicines supplied, reduce wastage and improve patient outcomes. Such QUM initiatives have been trialled and established in health services in regional and remote settings, where a pharmacist is directly employed to work with health centre staff to:

- provide onsite clinical review (similar to that considered under the HMR model),
- assist in meeting legislative requirements, and
- undertake continuous quality improvement activities.

Directly funding the health service to provide this service could also incorporate the use of interpreters and community liaison officers to support pharmacist services, either on site or during visits. This would promote cultural safety and greatly improve the delivery of QUM to clients.

As medicines adherence can pose a significant barrier in improving health outcomes, measures to improve this requires consideration. It is acknowledged that client adherence can be difficult to measure in remote communities due to the variability in documentation and the mobile nature of

clients. A measure that could, however, facilitate adherence would be to supply medicines in dose administration aids (DAA) where appropriate. This measure however is not funded under the S100 system, reducing the potential benefit. One possible solution would be to incorporate a DAA support allowance, similar to that funded by the Department of Veterans Affairs, into the current arrangements to the supplying pharmacy.

(c) the degree to which the 'quality use of medicines' has been achieved including the amount of contact with a pharmacist available to these patients compared to urban Australians;

Under the current arrangements, direct contact between pharmacists and clients is almost non existent. The model of care and facilitation of QUM that exists under this arrangement is not comparable to that in an urban setting where pharmacist led QUM activities are customary.

Some S100 pharmacy providers contracted to provide services to the NT Department of Health do provide a phone service during working hours to facilitate contact, but this is rarely used by clients. When it is used it is often health centre staff who act as intermediaries.

When the current arrangements were implemented, the understanding was that any existing resources being used to fund medicines would be redirected to supporting QUM activities. This could include pharmacist visits to remote communities giving clients greater opportunity for interaction with pharmacist, facilitating medicines understanding and adherence. This proved a naive view as it did not consider the infrastructure required to support such a service or workforce shortages. The shortages seen since that time meant that implementation of QUM activities have been negligible.

When compared with the availability of contact within an urban setting, the current arrangements provide little opportunity to resolve QUM issues and as such, the disparity is substantial. As mentioned above, provision of funding to health services to implement pharmacist led QUM activities would be a logical progression, supplementing the supply benefits of the current arrangements.

(d) the degree to which state/territory legislation has been complied with in respect to the recording, labelling and monitoring of PBS medicines;

The degree to which state and national legislation is complied with when supplying medicines to clients varies depending upon the mechanism under which it is supplied.

The NT Government has contractual arrangements in place for S100 pharmacies that supply medicines to NT Department of Health (DoH) managed health centres. One stipulation under this contract is for contracted pharmacies to dispense record and label medicines in accordance with NT legislative requirements when medicines for individual clients with chronic conditions are being supplied. This measure is designed to enhance both legislative compliance and clinical safety. This measure, however, is not funded under the S100 arrangements. As such there is significant risk to the sustainability of the measure and, by separating the management of these medicines from the S100 arrangements, it creates cumbersome dual administrative requirements.

For medicines provided from the health centre to manage acute presentations, the labelling and recording of supply varies. This is in part due to the limited availability of IT infrastructure, which means that much of the labelling is still done by hand, creating variability in the quality of labelling.

Equally documentation of supply varies depending on local IT systems, and clinical workload. Monitoring of client compliance is therefore difficult, partially due to this variability, compounding some of the QUM issues faced in this setting.

Both recording and labelling standards need to be understood in the context of remote health service delivery. Remote Area Nurses (RAN) and Aboriginal Health Workers (AHW) are asked to perform duties associated with supply of medicines in addition to their clinical duties. Health services are not resourced to provide the supplementary support to staff to assist with these additional tasks.

A potential solution would be to support contracted pharmacists in dispensing and labelling medicines for clients, when they are being supplied for chronic conditions. An increase in the handling fee paid to reimbursement would ensure legal obligations are being met and also that client compliance can be better monitored, supporting medicine related quality improvement activities.

(e) the distribution of funding made available to the program across the Approved Pharmacy network compared to the Aboriginal Health Services obtaining the PBS medicines and dispensing them on to its patients;

The current distribution of funding through the S100 arrangements has impacted two areas:

Firstly, as mentioned in the introduction, this arrangement has worked well to improve access to essential medicines in remote locations, in part due to collaborating with the well established supply systems of the community pharmacy network. In working closely with community pharmacies the arrangement draws on established corporate and technical knowledge to deliver a robust, efficient and secure medicine supply system which meets storage requirements.

The second area of interest is the safe and efficacious use of the medicines supplied. The deficiency in the current model lies in the promotion of QUM activity. This is partly due to the current funding model focussing on the supply component and not sufficiently compensating pharmacists for participation in QUM activity. The other contributing factor is that the arrangement supports a model where the pharmacist operates in isolation from the health service. As a result, the ability to develop strategic QUM programs, tailored to local needs and resources, is limited.

A commitment to supporting the local health services develop and deliver on-site QUM programs would be of advantage. One possible mechanism here is for this arrangement to fund health

services directly, so that they can develop and deliver specific QUM programs. This could be developed to be consistent with local need and resources and draw on pharmacy expertise, either employed directly by the health service or secured from external pharmacy providers.

(f) the extent to which Aboriginal Health Workers in remote communities have sufficient educational opportunities to take on the prescribing and dispensing responsibilities given to them by the PBS bulk supply arrangements;

The current S100 arrangements do not support the delivery of appropriate educational activities to assist with current need. Very little specific education and support is provided to AHWs, by visiting pharmacists. Once again, this highlights the deficiencies of the current arrangements in supporting QUM. AHWs form an integral part of the medicine supply arrangements at the health centre level and form a pivotal role in engaging clients into the medicine use process. Ensuring that they are integrated into a QUM program allows them to act as cultural brokers facilitating QUM.

Aboriginal Health Workers (AHWs), working under the provision of Section 29 of the NT Poisons and Dangerous Drugs Act, are authorised to supply medicines in accordance with endorsed clinical protocols. Training is required in this regard. However, the education that does exist is generally delivered by external Registered Training Organisations, but is accessed inconsistently.

While the formal education component exists, the current level of competency varies for AHWs working in remote health services to supply scheduled medicines. This is in part due to the lack of formal competency standards relating to QUM for AHWs. Given that the management of medicines forms a substantial part of daily practice for AHWs, there is a definite scope for QUM related educational activities and development of a set of nationally endorsed competencies.

In reviewing the S100 arrangement, consideration should be given to dedicated allocation of resources to support specific medicines related educational activities for AHWs. This would allow AHWs to safely and effectively deliver their contribution to QUM.

(g) the degree to which recommendations from previous reviews have been implemented and any consultation which has occurred with the community controlled Aboriginal health sector about any changes to the program;

Since the implementation of the current S100 arrangements, multiple reviews have been undertaken. While these have identified significant deficiencies in the current service delivery model, with respect to QUM, the recommendations from these reviews have not been implemented. This lack of evolution of the current arrangement has meant that areas of need are not being responded to by the program, greatly undermining its ability to improve health outcomes in this setting.

NT DoH is unable to comment on the scope of consultation that has occurred with the Aboriginal Community Controlled Health sector, during the course of these reviews.

(h) access to PBS generally in remote communities; and

As mentioned previously, the current S100 arrangement has been beneficial in addressing some access to essential medicines barriers, but significant deficiencies exist thus reducing the potential impact of this program in improving the health status of remote dwelling Indigenous people (see response to question (a) for further detail). Even in the circumstances where it has improved access, the current arrangement has done little to facilitate the safe and judicious use of PBS medicines in remote communities.

(i) any other related matters

There are currently several programs in existence that aim to improve the health status of Indigenous Australians, by improving access to essential medicines. These include the CTG initiative, legacies of the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Clients (QUMAX) and S100. These programs tend to operate in isolation from each other and while they should complement each other to assist Indigenous clients better manage their health, they do not effectively address the needs of highly mobile Indigenous clients in the Northern Territory. The following case study illustrates a typical scenario that clients face regularly:

An Indigenous client residing in a remote location is discharged from a hospital with a 7 day supply of medication. He is informed that he needs to attend an outpatient review in 2 weeks and elects to stay in a hostel in the urban setting, thus he no longer qualifies for medicines to be supplied under S100 arrangements. There is an expectation that he could present to the urban AMS on day 6 to access further medicines under the CTG initiative. However, this expectation creates several issues:

Firstly, the AMS medical practitioners are expected to prescribe medicines for a client they do not know, who may have complex conditions, often without appropriate information about the client's current health status. This creates risk for both the client and the clinician and often impacts on continuity of care, clinical outcomes and may lead to readmission into hospital.

Secondly, urban AMSs are often not resourced to provide service for remote clients, as their funding is based on their local population. As a result they are often unable to see clients at short notice, for prescriptions to be provided. This perpetuates the issues around discontinuation of medicines and negatively impacts on management of health conditions.

Lastly, registration and administrative requirements of the CTG initiative may be perceived as formidable by either the AMS or client. Relative to the short term nature of the scenario, this could be a barrier to continuation of treatment.

There is a strong imperative to rationalise and streamline the multiple funding models to allow integration of the current initiatives, or provide more flexibility in the design to acknowledge the realities of this highly mobile client group. Thus the effectiveness of each program would be increased and illness could more effectively be managed.

Another area for consideration regarding the program is the inclusion of local capacity building. Under this arrangement, there is little provision for the development of local resources to facilitate QUM. In other settings the development of a dedicated medicines support worker from the community has shown benefit. Having a local resource with specialty training allows better on

site management of medicines, better understanding of the local requirements and assists in capacity building of the Indigenous workforce. Consideration should be given to supporting a role such as this, through the development of key competencies and implementation of funded training programs.